Cancer Detection Programs: Every Woman Counts
RECIPIENT ELIGIBILITY FORM

Top section to be completed by patient

Cancer Detection Programs:
Every Woman Counts

Patient ID [ ] [ ] [9] [A] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ] [ ]

1. Last Name

2. First Name

3. Middle Initial

4. Social Security Number

5. Date of birth (Month--MM) (Day--DD) (Year--YYYY)

6. Address

7. City

8. State

9. ZIP Code

10. Telephone

11. Are you Hispanic or Latino?
☐ Yes
☐ No

12. Select all that apply to you
☐ American Indian or Alaska Native
☐ Asian → **13. (Select one if Asian)**
☐ Black or African American
☐ Pacific Islander
☐ White
☐ Unknown

13. (Select one if Asian)
☐ Asian Indian
☐ Cambodian
☐ Chinese
☐ Japanese
☐ Korean
☐ Laotian
☐ Vietnamese
☐ Other Asian

14. (Select one if Pacific Islander)
☐ Filipino
☐ Guamanian
☐ Hawaiian
☐ Samoan
☐ Other Pacific Islander

15. Total number of family members living together (applicant, spouse, children aged 20 and younger):

16. Total gross monthly income of family members:

17. I have no health insurance: ☐ None

I have this kind of health insurance:
☐ Medi-Cal   ☐ Medicare Part B
☐ Military   ☐ Family PACT
☐ Private insurance   ☐ Other _____

I certify that the above information is correct and complete:

_____   _____
Recipient signature   Date Signed

PROVIDER USE ONLY Eligibility Checklist

Supporting documentation on file establishes that recipient:

18. ☐ Meets program's age criteria for breast and cervical cancer screening and diagnostic programs.
    [> 40 years of age for Breast Services or > 25 years of age for Cervical Services]

19. ☐ Meets program's income and insurance criteria for breast and cervical cancer screening and diagnostic programs.
    [< 200% Federal Poverty Level; Payor of Last Resort: Unmet Share Of Cost, Unmet deductible, Exhausted Family PACT, No Medicare Part B]

20. ☐ Recipient referred for Breast and Cervical Cancer Treatment Program (Optional).

21. ☐ Signed program's consent form.

I have determined that this woman is eligible for CDP services*.

_____   _____
Primary Care Provider Staff Certifying Signature   Date Certified

To be eligible for program participation, clients must meet age, income and health insurance criteria. All three must be met for eligibility

Eligibility determination policies and information are located in the Cancer Detection Programs' Section of the Medi-Cal Manual.

Complete all fields. Place original in patient chart
Eligibility Form (12/05)